Gi Specialists of Clarksville, PC · Anil Patel, MD MBA, PC

Name: ____

Address: ______________________ City: ______________ State: ____ Zip Code: __________

Home # : ______________________ Work #: ______________________ Cell #: ______________________

Date of Birth: ______________ Age: ________ E-mail address: ______________________

Social Security #: ______________________ Employer: ______________________

Marital Status: ______ Spouse's Name: ______________ Spouse's Employer: ______________

Emergency Contact: ______________________ Phone Number: ______________________

Family Doctor: ____________ Referred By: ____________ Gastroenterologist seen in past: ____________

↓↓ Please initial below so that we know you have been informed of the following office and insurance policies. ↓↓

HIPAA POLICY

1. May we leave a message on your answering machine to confirm an appointment and/or procedure? Yes No N/A
2. May we leave a message on your answering machine when we make our courtesy post operative phone call? Yes No N/A
3. Do we have your permission to leave a message with anyone who answers any of the phone numbers listed above? Yes No
4. Do we have your permission to leave test results with anyone who answers phone or leave a message on answ machine? Y N

I have read and understood the HIPAA Privacy Practice Notice. **Initial:** ____________

OFFICE POLICY

There will be a $25 charge for a copy of your medical records. There will be a $25 charge for a returned check due to insufficient funds. You will be charged $75 for any appointment not cancelled prior to visit, for missing an appointment. You will be charged $150 for any procedure not cancelled prior to scheduled slot, for a No Show appointment.

Initial: ____________

INSURANCE BILLING POLICY

Please give us all primary, secondary and tertiary insurance coverage information at the time of registration. We will make a photocopy of the insurance cards for our records. Insurance information not provided at the time of registration will be your responsibility and payment for the services will be expected. There will be a $25 charge for any insurance that needs to be resubmitted due to lack of information or incorrect information. The account balance will be due within 90 days of the service and treatment date.
If an outpatient procedure, lab work, or a x-ray is required, then your insurance will be billed separately by the physician, the outpatient surgery facility, and the laboratory.
Please be aware that screening office visits and screening procedures may not be covered by your insurance plan.
It is your responsibility to call your insurance company to verify benefits.

Initial: ____________

TEST RESULTS POLICY

When you have any type of laboratory test, x-ray, biopsy, or other report pending, it is our office policy to request that you call if you have not received results within 10 days and you are not scheduled for a follow-up appointment. We do not want you to assume that results are normal if you have not heard from this office. This policy was adopted to ensure that we do not overlook any of our patients and to implement a program that involves each of you in your medical care.

Initial: ____________

ASSIGNMENT OF BENEFITS and RELEASE OF INFORMATION

I authorize direct payment of surgical/medical benefits to Dr. Anil Patel and Gi Specialists of Clarksville, PC for services rendered by him in person or under his supervision.
I understand that I am financially responsible for any balance not covered by my insurance.
I authorize Dr. Anil Patel to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of these assignments shall be valid as the original.
If this account goes delinquent, I will be responsible for all collection agency and/or attorney fees, and all other costs.

SIGNATURE: ______________________________ **DATE:** ______________

Chart No. ____________ 000 Witnessed by ____________